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AUTHOR Neugroschel, William J.; Notzon, Linda R.
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ABSTRACT

Since nursing home placement is frequently the last choice for families of elderly people who need long-term care, little literature exists which delineates a model for consumer decision making in the selection of a specific long-term care facility. Critical issues include the following: (1) who actually makes the selection; (2) what other individuals influence this decision; (3) what facility characteristics are important; and (4) how the decision is made. To explore these issues, a survey of over 400 families of nursing home residents was conducted. Results explored a 5-stage decision making model (need, input, visitation, evaluation/selection, validation). Findings indicated that a resident's relative most often made the facility selection decision, with help from the family doctor, and that the resident's opinion was infrequently ranked important. Facility location emerged as a major selection factor with most respondents limiting driving time to 20 minutes. The most important facility characteristics according to families included cleanliness, level and quality of care, attitude and competence of staff, and food quality. Further research is needed to determine whether the elderly are voluntarily giving up their control of the selection decision. In addition, educational programs should be implemented to help families and prospective residents evaluate the differences between the medical and social services being provided in various long-term care facilities. (Author/ABL)

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A MODEL OF CONSUMER DECISION MAKING IN THE SELECTION OF A LONG-TERM CARE FACILITY

William J. Neugroschel, M.S.W., M.B.A.

Linda R. Notzon, M.Ed., M.P.H.

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Since nursing home placement is frequently the last choice for families of elderly people who need care, little literature exists which delineates a model for consumer decision making in the selection of a specific long-term care facility. Critical issues include who actually makes the selection and what other individuals influence this decision; what facility characteristics are important; and how the decision is made.

To explore these issues, a survey of over 400 families of nursing home residents was conducted. Results which explore a 5 stage decision making model (need, input, visitation, evaluation/selection, validation) are discussed. Findings indicate that a resident's significant other most often makes the facility selection decision, and that the resident's opinion was infrequently ranked important. Facility location emerges as a major selection factor - most respondents would limit driving time to 20 minutes. The most important facility characteristics according to families include cleanliness, level and quality of care, attitude and competence of staff, and food quality.

The authors conclude that additional research is needed to determine whether the elderly are voluntarily giving up their control of the selection decision. In addition, educational programs should be implemented to help families and prospective residents evaluate the differences between the medical and social services being provided in various long-term care facilities.

INTRODUCTION

Health is one of the primary concerns of older adults. The increasing numbers of elderly individuals in the population will place greater demands on the health care sector to meet the unique and special needs of this population. Many health services are used exclusively or primarily by the elderly. These services vary greatly, both in the type of social and/or medical needs they are designed to meet and in the type of reimbursement available. Because of the many alternatives available in the long-term care system, the demand for the services of a specific provider will be highly dependent upon individual consumer choice.

The challenge for the nursing home sector of the long-term health care field is to identify the person making the nursing home selection decision, determine the decision making framework operating at the time, insure that appropriate information is being supplied, and evaluate the success of the placement from the perspective of both the decision maker and the recipient of service.

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Need Identification

Clearly, the mission of the long-term care facility is to provide medical, nursing, nutritional, social and personal care services to those whose physical status require such support. Many models for needs assessment have been developed to determine whether someone truly requires this type of institutional care. The evaluative process takes place through the interaction of health care professionals with the client to determine his/her functional capabilities. Once need has been established, the process for selecting a specific long-term care facility begins.

The decision as to which long-term care facility is selected is a discretionary one. Personal experience, values, and information-seeking over time can contribute to the outcome of the selection process. Individuals engaged in this process may exhibit many of the same characteristics referred to in the marketing literature when consumer behavior during the purchase of non-health care goods or services is described.

Philip Kotler (1982) identifies five buyer roles:

1. **Initiator.** The initiator first suggests or thinks of the idea of buying the particular product or service.
2. **Influencer.** An influencer has views or advice which influence the final decision.
3. **Decider.** The decider ultimately determines any part or all of the buying decision: whether to buy, what to buy, how to buy, or where to buy.
4. **Buyer.** The buyer makes the actual purchase.
5. **User.** The user consumes or uses the product or service.

If this model is applied to the nursing home selection process, the implication is that the decider or the buyer of the services of the nursing home may not be the same as the user of the services, i.e., the long-term care resident. Previous research supports this conclusion.

Furse (1983) suggests that to presume the nursing home resident is the "consumer" of nursing home services is only half right. Families of nursing home residents are the other half of the market. Both Froebe, et al (1982) and Smith (1984) supported this finding. Goldstucker, et al (1974:18), through actual interviews with doctors, families and residents, concluded that "when comparisons are made between nursing homes, it is usually the patient's family who makes the comparison and actually chooses the nursing home for the patient".

In 1979, Kaplan identified the physician and the hospital discharge coordinator as the major influencers in the facility selection process. This is supported by Dr. Mitchell Berdie (Pace and Anstett, 1984:35) who stated, "It is important for the physician to indicate that this decision is a family responsibility."

Consumer Decision Making Models

When reviewing the literature, several models of the consumer buying process appear. A five stage model is suggested by Kotler (1982): 1) need arousal, 2) information gathering, 3) decision evaluation, 4) decision execution, and 5) post decision

assessment. Lavidge and Steiner (1961) suggest a similar six-stage model ranging from awareness through the stages of knowledge, liking, preference, conviction, and purchase. These models allow us to consider what needs and wants give rise to interest in a particular nursing home; what the decision maker does to gather information; how much information he is likely to gather before making a decision; what information sources will be used, and how much influence these sources will have on the final selection decision.

Horton (1984) describes three decision making hierarchies which can be used depending upon the situational factors underlying the buying process. The learning hierarchy is used when there are important differences among the choice alternatives and the consumer feels competent to recognize and evaluate these differences. The low involvement hierarchy is used when the consumer has not thought about the purchase decision before a fairly immediate need arises; there is low ego involvement in the purchase and a previous strong positive judgment about the product has not been made. At this point, the consumer will typically purchase a brand name. Finally, dissonance/attribution theory is used when the consumer is forced to make a choice quickly, usually on the basis of personal communication, with little opportunity to acquire information or cognitions to support the choice.

Based on Horton's description, it may be this latter hierarchy which comes into play during the nursing home selection decision. The consumer is highly ego involved and chooses among

alternatives where the differences may not be easily discernable. The source of persuasion that initiates the action is personal, i.e., the doctor or discharge planner.

Lenz (1984) contends that information seeking as a component of the decision making process is a basic step in the process of selecting medical services. The search process may incorporate two methods: the use of impersonal information sources such as books or pamphlets or persons unknown to the searcher, or the use of information which is provided by someone known personally to the searcher. Lenz indicates that the scope (number of alternatives investigated) and the depth of the selection process (number of dimensions of the alternative investigated) may also vary.

Decision Evaluation

Consumer decision models indicate that, after the information gathering phase, the consumer develops a list of attributes or variables which will ultimately dominate their final choice. This incorporates such factors as their reaction to the benefits and attributes of the nursing home, previously held beliefs about the value of nursing home care, and the degree to which a particular nursing home will satisfy their perceived needs.

Froebe, et al, (1982) described how consumers ranked the importance of such facility attributes as quality of care, location, cost and appearance in the facility selection process. Smith (1984) determined that cleanliness of the

facility, competency of the medical staff, safety, pleasantness of the staff and atmosphere were of primary importance. Goldstucker's case study (1974) supports both Froebe and Smith in the areas of reputation, type of care, friendliness of staff, and cleanliness, but indicates that only half of the respondents felt that price and location were important factors in the selection process.

Study Hypotheses

Conscientious health care managers must know their consumers, determine how they make choices when purchasing health care services, recognize from the consumer's perspective those service attributes that are most important, and then design a communication/education process to assist the consumers in their decision making efforts. In order to explore these areas, a proprietary long-term care company conducted a study of the facility selection process.

The objective of this study was to test the following hypotheses:

Hypothesis 1 The recipient (user) of nursing home care is not the decision maker who determines from which nursing home s/he will receive services.

Hypothesis 2 The consumer or decider (usually a family member) is substantially influenced by physicians and/or discharge planners during the long-term care facility selection process.

Hypothesis 3 Facility attributes not specific to the medical care needs of the prospective resident are the key factors influencing the facility selection process.

Hypothesis 4 The consumer uses a five stage decision making model to select a specific long-term care facility. The five stages are need identification, input, visitation, evaluation/selection, and validation.

METHODOLOGY

The population surveyed in this study consisted of 901 families that, as of July, 1984, had family members residing in long-term care facilities owned by a major proprietary long-term care corporation. These facilities were located in one northeastern, one midwestern, and one southwestern state. In order to focus the study on consumers that were thought to have the widest range of choice in the selection of a long-term care facility, the study excluded families of residents whose care was reimbursed by the Medicaid or Medicare programs.

A 41 item questionnaire was mailed to the above population in August of 1984. A total of 431 useable surveys were returned, which constituted a 47.8% response rate.

A comparison of the characteristics (age distribution, level of care, and level of disability) of the nursing home populations of the three states included in the study showed that they are similar to those of the nursing home population in the U.S. as a whole. Although we cannot determine whether the sample of respondents was representative of the population studied, an inspection revealed that the demographic characteristics of respondents were similar to the distribution of characteristics that we expected. Thus, we believe these respondents to be

fairly representative of the population that is the subject of this study.

To determine whether the respondents were the actual decision makers with respect to the selection of a specific long-term care facility for their family member, we asked them to indicate to what extent they were responsible for the selection decision. The average amount of responsibility indicated was 79%, which gives us a high degree of confidence that our respondents were the actual decision makers. Forty nine percent (49%) of our respondents indicated they were 100% responsible for the selection decision.

Table 1 presents a summary of the demographic characteristics of the respondents. As shown by the data, most respondents were married women; only 7% were under age 40, 44% were between the ages of 40 to 59 years, and 45% were older than 59 years. When missing values were eliminated from the percentage calculations, more than one third of the respondents (36.3%) had family incomes of less than $10,000 to $20,000, 33.5% had family incomes between $20,000 and $40,000, and 24.6% had incomes between $40,000 and $75,000 (N = 325).

About twenty eight percent (28%) were high school graduates, 41% had some college or were college graduates, and 17% had some postgraduate study or a graduate degree. One third of the respondents were the daughters or daughters-in-law of the residents, while 23% were sons or sons-in-law.

TABLE 1

Demographic Characteristics of Respondents

Age	%
20 to 39 years	7%
40 to 59 years	44%
60 to 69 years	29%
70 or older	16%
missing	4%

Sex	%
Male	39%
Female	58%
missing	3%

Annual Family Income	%
Less than $10,000 to $20,000	27%
$20,000 to $40,000	26%
$40,000 to $75,000	18%
Over $75,000	4%
missing	25%

Level of Education	%
Less than High School Graduate	9%
High School Graduate	28%
Some College	25%
College Graduate	16%
Some Post Graduate Study	5%
Graduate Degree	12%
missing	4%

Relationship to Resident	%
Spouse	7%
Son/Son-In-Law	23%
Daughter/Daughter-In-Law	34%
Sibling	9%
Other	24%
missing	3%

Length of Residency of Family Member in Company's Long-Term Care Facility	%
0-12 months	32%
13-24 months	18%
25-36 months	11%
37-60 months	7%
Over 60 months	9%
missing	23%

Marital Status	%
Married	79%
Single	5%
Widowed	10%
Divorced/Separated	3%
missing	3%

(N=431)

RESULTS

In this section, the findings of the study in relation to the study hypotheses will be presented. In addition, other findings which review the relative importance of interpersonal influencers on the facility selection process versus facility attributes will be discussed.

Hypothesis 1

Previous research by Furse (1983), Goldstucker, et al (1974), and Smith (1984) found that the prospective long-term care resident is not the decision maker in the facility selection process. Our study confirms this hypothesis. At least 73% of the time, a family member of the prospective resident made the selection decision for the resident. In fact, over half of the individuals who responded to the survey believed that all (100%) of the actual selection decision was up to them, and, on the average, the respondents felt that most (79%) of the decision was their responsibility. This finding is confirmed by the data in Table 2. The prospective facility resident's input was ranked first in importance in the selection decision only 8.6% of the time.

It is interesting to note that the location of the facility to the prospective resident's previous home was ranked important or very important to the selection decision by less than half (42%) of the respondents, while facility location relative

TABLE 2

Ranking of Individual's Opinions According to Importance in Determining Facility Selection

Individual	Times Ranked First in Importance (%)
Other Family Members	8.6%
A Family Doctor	17.6%
Social Worker, Counselor, or Other Medical Personnel	9.7%
Family Clergyman	.7%
Your Own Personal Opinions	30.4%
Prospective Facility Resident	8.6%
Neighbor or Friend	1.9%
Other	3.2%
missing	19.3%

TABLE 3

Respondents Rate Importance of Other's Recommendations on Facility Selection Decision

Recommendations From:	No Importance At All %	Little, If Any Importance %	Fairly Important %	Important %	Very Important %
Friends or Neighbors	30	10	19	20	21
Other Family Members	32	5	12	22	29
Family Doctor	19	5	14	22	40
Other Medical Personnel	32	7	16	21	23
Social Worker or Counselor	32	8	15	21	23
Your Clergyman	49	10	16	13	11

to the respondent's own home was ranked important by the majority (73%) of the respondents. In fact, although 56% of the respondents reported that location of the nursing home was not the most important factor considered in the selection process, the majority (64%) of the respondents said that facility location was a "major" factor. Sixty percent (60%) of the respondents reported their homes were within 20 minutes driving time from the long-term care facility they selected, and 78% said they lived within 30 minutes of the selected facility.

Hypothesis 2

Previous work by Kaplan (1979), Froebe, et al (1982), and Smith (1984) found that a family member's personal physician and hospital social workers had a substantial influence on the facility selection process. Our study confirms the existence of this kind of effect. Table 2 displays the percentage of times that an individual or group's opinions were reported as "first in importance" to the individual making the facility selection decision. Respondents ranked their "own personal opinions" as first in importance 30.4% of the time, followed next by input from their family doctor (17.6%). The opinions of a social worker, counselor, or other medical personnel were ranked first in importance only 9.7% of the time. Thus, the opinions of family physicians and social worker/counselors were more important to the decision maker than the opinions of the prospective facility resident, other family members, or others.

The respondents were also asked to rate on a 5 point scale the level of importance they assigned to others' recommendations relative to the facility selection process. Table 3 displays these results. Here again, the family doctor was the most important external interpersonal influencer on the selection decision. The family doctor's opinion was rated important or very important by 62% of the respondents. Other significant selection influencers included other family members (51%), social workers, counselors, and other medical personnel (44%), and friends or neighbors (41%). These results show that, after the decision maker's own opinions are taken into account, the family physician is the most significant influence on the selection process, followed by social work counselors and other medical personnel. The recommendations of other family members are also viewed as important.

Hypothesis 3

Previous researchers in this area (Froebé, et al, 1982; Smith, 1984) have found that facility attributes not directly specific to the medical care needs of the prospective resident are the key factors influencing the facility selection process. The results displayed in Table 4 support this hypothesis. Almost all of the respondents (94%) ranked facility cleanliness as an important or very important factor in the selection process, while 90% ranked the perceived level and quality of care as important or very important; 89% ranked attitude and competence

TABLE 4

Respondents Rate Importance of
Facility and Staff Attributes on Facility Selection Decision

	No Importance At All %	Little, If Any Importance %	Fairly Important %	Important %	Very Important %
Location Relative To Decision Maker's Home	10	7	10	24	49
Location Relative To Prospective Resident's Home	37	11	10	16	26
Cleanliness	3	.5	3	16	78
Level & Quality of Care	5	1	3	17	73
Attitude & Competence of Staff	5	1	5	22	67
Quality & Variety of Meals	6	4	12	31	47
Reputation	11	4	10	21	54
Attractiveness of Grounds & General Appearance	5	6	23	42	24
Safety of Surrounding Area	10	5	14	29	41
Size of Resident Rooms	7	5	28	38	22

of staff as important or very important, 78% ranked the quality and variety of meals, and 75% ranked the facility's "reputation" as important or very important. Other facility characteristics perceived as important or very important include the safety of the surrounding area (70%) and the size of resident rooms (60%).. By comparison, only half of the respondents ranked the availability of a physical therapy program as an important or very important factor in the facility selection process.

Hypothesis 4

The authors have proposed the existence of a five stage model of consumer decision making which includes the stages of need, input, visitation, evaluation/selection, and validation. Elements of this model have been described in previous research by Kotler (1982) and others. The results of this study support the five stage model. Although the survey did not directly attempt to measure the perceived "need" for a long-term care facility, a review of focus group sessions conducted with family members revealed that the perceived need for nursing home placement can be externally or internally generated. That is, this need can arise because of an external event such as an accident or the onset of a disabling condition or disease, or can be generated internally, when, for example, a family decides it can no longer care for an elderly family member at home.

The existence of the input stage of the theoretical model is confirmed by the study. It is clear from the answers supplied by respondents that they did consider the opinions of various input sources, including family doctors, other family members, social workers and other medical personnel, the prospective resident, and clergy.

The visitation phase of the model is also confirmed by the study results. Sixty six percent (66%) of the respondents reported that they visited more than one nursing home in making a final selection for their family member. Twenty-one percent (21%) of these respondents visited 2 facilities, 34% visited 3 facilities, 19% visited 4, and 21% visited 5 or more facilities. After visiting an average of 3.3 facilities, the consumer evaluated the facilities using the recommendations of significant others and the facility and staff attributes which were discussed under hypothesis 3; after that, the respondent selected a long-term care facility for the prospective resident.

Finally, the decision maker sought to validate their facility choice. An examination of responses to an open ended survey question reveals that once the decision maker has reached a tentative facility selection, s/he will seek to validate or confirm that the proposed choice is the "right one" by checking with the family physician, social workers and other medical personnel, family members, friends and the prospective resident.

Other Findings

We also wanted to assess whether the opinions of significant others were more powerful than factors such as the physical and programmatic attributes of the long-term care facility with respect to their influence on the facility selection process. Table 5 displays both the percentage of respondents who rated a factor important or very important, and the overall ranking that the respondents gave to each specific factor. It is interesting to note that, almost without exception, the physical attributes of a facility such as "cleanliness" or a programmatic factor such as "level and quality of care" were rated by respondents to be more important than the opinions of others.

In fact, physical and programmatic factors accounted for the top nine ranked items, followed by interpersonal influences. The recommendations of a family doctor were ranked tenth in importance by respondents, followed by the recommendations of significant others such as family members. In summary, physical properties of a facility and the characteristics of its staff were viewed as being more important with respect to the facility selection process than external, interpersonal factors such as the recommendations of medical personnel, family, friends and clergy.

TABLE 5

Respondent's Overall Ranking of Interpersonal Influencers and Facility or Staff Attributes

	%	Ranking
Cleanliness	94	1
Level & Quality of Care	90	2
Attitude and Competence of Staff	89	3
Quality and Variety of Meals	78	4
Reputation	75	5
Location Relative to Respondents Home	73	6
Safety of Surrounding Area	70	7
Attractiveness of Grounds	66	8
Size of Resident Rooms	60	9
Recommendations of Family Doctor	62	10
Availability of Physical Therapy	52	11
Recommendations of Other Family Members	51	12
Recommendations of Other Medical Personnel and Social Worker	44	13
Location Relative to Prospective Resident's Home	42	14
Recommendations of Friends or Neighbor	41	15
Your Clergyman	24	16

Notes: "%" = percentage of respondents that judged the factor to be an important or very important factor in the facility selection process; "ranking" = the overall rank of which factors the respondents rated as most important with respect to selecting a facility.

CONCLUSIONS AND RECOMMENDATIONS

This study confirmed the hypotheses of the authors and supported the previous work of other authors. In summary, the recipient of care in nursing homes is generally not the decision maker with respect to the facility selection process. The selection is usually made by a member of the family who is substantially influenced by a physician or other health care professionals. Family members tend to select a facility based on the geographic proximity of the facility and on their perceptions of the quality of care being provided. The indicators of quality used by the decision maker include cleanliness, the perceived attitude and competence of staff, the quality and variety of meals, and the reputation of the facility. The decision maker did not include such factors as medical specialties, nursing expertise, or program capabilities related to resident care needs. These findings have great implications for long-term care providers.

The manner in which referrals are made among hospitals and nursing homes creates an obstacle for the continued involvement of the elderly person in their own care decisions. Generally, hospital teams develop the discharge plan and send the families to "find a nursing home bed." Beds in a long-term care facility are not for sale as are beds in a hotel. Instead, nursing homes provide a package of nursing and social services designed to keep people as medically stable and functionally independent as possible within a protected environment.

The assurance of opportunities for independence, choice, identity and socialization within the nursing home are key elements of nursing home programming, and yet the referral system, operated in the manner described, eliminates the older person's control of and opportunity for choice in the placement decision itself. As care givers, we must determine the reasons for this. Are potential residents unable to make this choice, or are we reluctant to bring long-term care admissions counselors to the acute care facility to explain their services to the prospective resident, who could then participate in the decision? The latter would indeed be a shift from current practice.

It is not clear from this study why or if prospective residents are abdicating their responsibility for their care, or if we are merely allowing the system to bypass this responsibility. Additional research should be conducted to determine if the elderly are voluntarily giving up their control of the facility selection decision, or if more strenuous efforts need to be made to include them more fully in the process.

As the current decision maker, families in general are not adequately knowledgeable to select a long-term care facility based on its ability to meet the special medical care needs of the prospective resident. Our study, as well as the work of others, indicates that although families believe quality of care is important, their perceptions of quality relate to more obvious and possibly unrelated factors such as facility cleanliness, the absence of odors, and a home-like decor. Programs should be

implemented to educate families to ask questions more relevant to actual care delivery such as,"Who is the Medical Director? What is his/her area of expertise? What ancillary services are available (for example, equipment, special therapies, and consultants)? How are medications monitored? What is the quality assurance program? Describe your activities program."

One such tool which has been developed as a result of this study is a guide to selecting a nursing home (Meridian Healthcare, 1985). This guide highlights the service areas to review and the probing questions that a family can ask. Other such brochures are available through the U.S. Department of Health & Human Services (1976) and many local bureaus of consumer affairs. A brochure such as this can be the most important piece of information provided by discharge planners to families to assist them in becoming better informed decision makers.

Physicians, social workers and discharge planners have been identified as greatly influencing the selection of a particular nursing home. It is not clear to the authors what criteria these professionals use in making their decisions regarding the selection of one facility over another. More research should be conducted to determine the content of these workers' knowledge base. Do practitioners assess facilities on professional criteria related to patient care, or are facilities recommended based on their relation to the influencer's own personal hierarchy of needs? For example, does a discharge planner recommend a certain facility because s/he is aware that the facility has a bed available, or because the facility will admit

medicaid recipients? Before we can encourage physicians and discharge planners to educate families, we must be sure these professional referrers have a foundation of knowledge themselves regarding the services and expertise available in the facilities to which they refer.

In summary, managers of long-term care facilities can play a key role in improving the rationality of the facility selection process. The five stage decision model supported by this study illustrates each step in the decision process where administrators can intervene to help families and prospective residents move towards an appropriate and successful selection decision.

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